Business Requirements Overview

For

Medicaid Part D Program

01/28/2011

Medicaid Part D Business Requirement Overview

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1.0 Objective

The objective of this attachment is to provide a business requirements overview of the Montana Medicaid Part D program. This attachment includes a description of the program, the high level business requirements, and a description of the processes to be used to administer the program. Further detail about the Montana Medicaid Part D program is found in the main body of our waiver request.

2.0 Executive Summary

The purpose of the Medicaid Part D Program is to remove barriers to pharmacy coverage and to increase affordable prescription drug coverage for Montanans by extending Medicaid eligibility for a Medicaid prescription drug benefit through a Section 1115 Waiver. This prescription drug benefit is to offer prescription drugs at a lower price, which is the Medicaid Best Price, to all Montana residents, regardless of insurance status. Best price will be achieved in a two step process; first by offering Medicaid drug pricing at the pharmacy counter, then by passing on associated Medicaid drug rebates, less administrative costs. The Medicaid Part D Program will be available to every Montana resident that is not enrolled in Medicaid.

A draft proposal of the waiver to allow for the State of Montana to administer the Medicaid Part D Program was submitted to CMS for initial review on November 16, 2010. A public hearing was held on December 2, 2010, and comments were solicited for the past two months The Department has taken the public comment into consideration and is now submitting a formal request to CMS for approval of the Medicaid Part D program.
Oversight for this program will be provided by the Health Resources Division (HRD).

The Medicaid Part D Program will include four different business process components:

- Eligibility Determination
- Claims Processing and Pricing
- Rebate Collection
- Rebate Distribution

In October 2010, DPHHS staff met with representatives from Montana Interactive (MI) regarding a systematic solution that will be used to administer eligibility for the Medicaid Part D Program. This meeting resulted in the identification of requirements, and a determination that an online web application can be developed that will meet the needs of the program. Work has begun on the eligibility system so that Montana can implement Medicaid Part D as soon as CMS approval is received.

3.0 Medicaid Part D Business Processes

The business requirements identified in this section are high-level requirements, and are not intended to be at the level of detail necessary for coding and development. It is anticipated that detail level requirements will have to be gathered and documented prior to any actual coding of any systematic solution(s). The information provided below is intended to provide an understanding of what is needed in order to develop a systematic solution to administer the Medicaid Part D program.

The program will include four different processing components:

- Eligibility Determination
- Claims Processing and Pricing
- Rebate Collection
- Rebate Distribution

3.1 Eligibility Determination Process

The process for determining eligibility for the Medicaid Part D Program will be completely systematic. Eligibility will be determined in "real-time", by a systematic solution available only online. A participant will input specific information required to determine eligibility into the online application. The systematic solution will be required to interface with other systems or data sources in order to effectively determine eligibility.

In order to be eligible for the Medicaid Part D benefit, a participant must meet the following criteria:

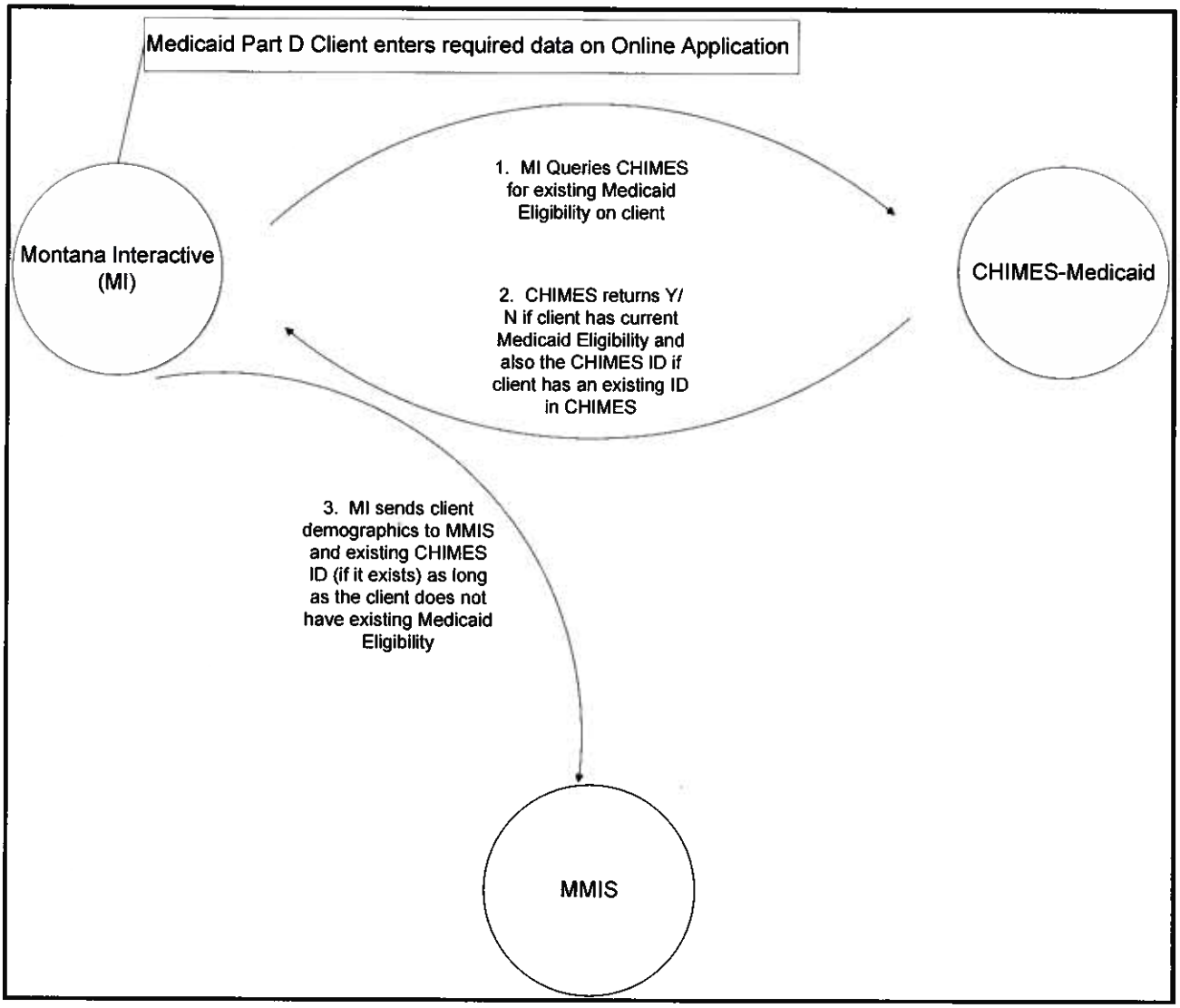
- Must be a Montana Resident
- NOT currently enrolled in a Medicaid program
- Legally residing in the United States
- Must have countable income below 200% of Federal Poverty Limit (FPL). Please note that any income above 200% of FPL will be disregarded

The information entered on the online application will be self-declared. Acceptance of self-declared information will require no staffing specific to determining eligibility.

This program is specific to an individual; hence only one individual will be determined eligible at a time. The benefit span will start on the date the eligibility determination was made, and will expire after one year. The client will be responsible for re-applying after expiration has occurred. Once determined eligible, a client will be able to print a "card" directly from the online application, displaying eligibility start and end dates.

In order to automate the Eligibility Determination process, it is necessary for an interaction to occur between multiple systems. This interaction is anticipated to occur through various means of interfaces / data exchanges. The following is a graphic depiction of how the data is envisioned to flow across systems to determine eligibility,

and include Medicaid Part D participant data in the Montana Management Information System (MMIS).



3.1.1 Online Application Requirements

The following high-level requirements are necessary in order for the Online Application, that will be used to determine eligibility, to operate effectively. The system must:

1) Allow the user to input necessary client information
   a) Name
   b) Mailing Address
   c) Date of Birth
   d) Annual Income
   e) Social Security Number
   f) State of Residency
   g) Race – Ethnicity (reporting)

h) Gender (reporting)
i) Available Insurance (Employer, COBRA, etc.) (reporting)

2) Be available to clients 24x7x365
3) Meet the security standards and expectations provided by the State of Montana
4) Allow a user to input multiple applications, i.e. filling out an application for self, and another a for a child
5) Provide ability to print a Medicaid Part D card
6) Require a user to login securely
7) Allow for a login id and password to be maintained by the client
8) Provide for data encryption for interfaces, as determined applicable
9) Provide for on-screen error handling and warning messages
10) Be able to send, receive, store, and process information from the Combined Health Information and Montana Eligibility System (CHIMES)
11) Be able to compile and send information to MMIS, using existing MMIS file layout
12) Store incomplete applications
13) Store complete applications, including historical applications
14) Allow for address and name updates to existing applications
15) Be intuitive and "user-friendly", i.e. include "Help logic"
16) Be able to make and store an eligibility determination for each application, including a "reason" for an application where eligibility is denied

3.1.2 MMIS Requirements

To satisfy the Eligibility Determination component, MMIS must:

1) Be able to receive and store client, eligibility, and program information from online application
2) Utilize the existing "duplicate resolution" process to help identify and resolve any potential duplicate clients

3.1.3 Interface Requirements

In order to determine eligibility for the Medicaid Part D program, it is necessary to send and retrieve data with two other systems.

CHIMES Interface

A real-time, two-way interface is needed with CHIMES, in order to assist in the determination of eligibility for each application. The Online Application will pass client identifying information to CHIMES. CHIMES will use the information to:

1) Check to see if there is an existing CHIMES Id for that client
2) Check to see if the client is currently enrolled in a Medicaid program that will make them ineligible for the Medicaid Part D program.

Any "matching" that is done with CHIMES will be done using key client identifying information, such as SSN, Date of Birth, and Gender. CHIMES will

return a CHIMES Id, if applicable, and a "yes" or "no" for current Medicaid enrollment

MMIS Interface

A one-way interface will provide the necessary Medicaid Part D client and eligibility information to MMIS. The MMIS interface will:

1) Receive client and eligibility information via Secure File Transfer Protocol (FTP) or other applicable State File Transfer service
2) Utilize the existing layout already prescribed for MMIS
3) Process Medicaid Part D application during nightly batch processing

3.2 Claims Processing / Pricing Process

The Claims Process / Pricing process is the method in which pharmacies will be able to use the existing "portal" and/or Point of Sale (POS) to:

- Inquire on eligibility for a Medicaid Part D client
- Determine if a specific prescription product is covered by the program
- Determine the price of the product (Medicaid best price)
- Determine payment responsibility from other sources (Private Insurance, Medicare, Veterans Administration, etc...)
- Determine client payment responsibility via the price they are expected to pay at the counter

This process is already established and utilized by other programs administered by the Department (i.e. Mental Health Services Plan and Medicaid Outpatient Plan). Specific to the Medicaid Part D program, a new plan code within the Prescription Drug Claim System (PDCS) will be created.

PDCS will be used to provide specific information necessary to complete the Rebate Collection process for Medicaid Part D program rebates. This information will include:

- Accumulated utilization by Client / National Drug Code / Provider
- Accumulated utilization to allow for invoicing each manufacturer on a quarterly basis
- Detailed information to support the existing rebate dispute resolution processes

The data input into and utilized by PDCS will be acquired systematically, through the use of existing interfaces, export / import processes, and other electronic means.

3.2.1 Online Application Requirements

The Online Application is not expected to be utilized within the Claims Processing / Pricing process.

3.2.2 MMIS Requirements

PDCS will be used for the Medicaid Part D Program to receive applicable information from MMIS. MMIS will ensure the Medicaid Part D client information

is available for and transmitted to PDCS. MMIS will utilize existing processes for other programs that require PDCS to be "populated" with MMIS information.

In addition a payment hierarchy will be developed in MMIS, to accommodate clients that are "dual eligible", ensuring payments are allocated properly.

3.2.3 Interface Requirements

The interface / data exchange process that is currently used by PDCS will be used for applicable Medicaid Part D information.

3.2.4 Assertions

The Claims Processing / Pricing component is based on the following assumptions:

1) MMIS can provide the necessary Medicaid Part D information to PDCS.

3.2.5 Risks

At this time, no risks for the Claims Processing / Pricing component have been identified.

3.3 Rebate Collection Process

The Rebate Collection Process is a process in which DPHHS will identify the accumulated distribution of pharmaceutical products by National Drug Code within a given period, and generate an invoice to the drug manufacturer requesting an accumulated rebate. For each product, the State negotiates a rebate amount. This process primarily involves the means to identify and obtain the rebates due.

This process involves taking information from the PDCS system, and using the Drug Rebate Analysis and Management System (DRAMS) to generate rebate invoices.

The DRAMS system is used to accumulate utilization information collected from PDCS that specifically identifies:

- Individuals in the waiver eligibility group
- The product dispensed, by National Drug Code
- The units dispensed
- The coverage / non-coverage of specific products in the process.

The rebate collection process is already in use by other programs within DPHHS (i.e. Mental Health Services Plan and Medicaid Outpatient Plan). The Medicaid Part D benefit will utilize this same process, but specifically identify which rebates are applicable for this program. Much of the information utilized in this process is provided by the Claims Processing process and its system (PDCS).

The information gathered for the Rebate Collection process will be done systematically, through the use of interfaces, export / import processes, or other electronic means.

3.3.1 Online Application Requirements
The Online Application is not expected to be utilized within the Rebate Collection process.

3.3.2 MMIS Requirements
MMIS is not expected to be utilized for the Rebate Collection process.

3.3.3 Interface Requirements
The interface / data exchange process that is currently used by DRAMS will be used for applicable Medicaid Part D information.

3.3.4 Assertions
The Rebate Collection component is based on the following assumptions:

1) DRAMS can electronically acquire and utilize applicable information from PDCS.
2) Limited modifications, if any, are required to the DRAMS, PDCS, or MMIS systems for the Rebate Collection Process

3.3.5 Risks
At this time, no risks for the Rebate Collection component have been identified.

3.4 Rebate Distribution Process
The Rebate Distribution Process is the means in which DPHHS will distribute the rebates collected on the products distributed specific to the Medicaid Part D program. Currently, there are no other programs within DPHHS that utilize a rebate distribution process where the rebates are distributed to the program participants. Other programs use a rebate distribution process that entails using the rebates to provide discounts, or pay for Medicaid services.

The Rebate Distribution process of funds collected via rebate:

- Use rebate funds to finance administrative costs
- Distribute the rebates back to the individual participants

The distribution of rebates will occur as often as quarterly, but no less than annually. The option of how to distribute the rebate monies and the frequency of distribution will be identified by authorized DPHHS staff.

3.4.1 Online Application Requirements
The Online Application is not expected to be utilized within the Rebate Distribution process.

3.4.2 MMIS Requirements
MMIS may be used to identify demographic information specific to Medicaid Part D program participants that will be included in the Rebate Distribution process.

This information may be required to be compiled and "transferred" to the agency or persons responsible for distributing applicable rebates to participants.

3.4.3 Interface Requirements

There may be a need to provide Medicaid Part D client and rebate information via a one-way interface with the agency or persons responsible for distributing rebates.

3.4.4 Assumptions

Rebate distribution to Medicaid Part D participants will be handled by partnering agencies, such as the Department of Revenue (DOR)

3.4.5 Risks

At this time, no risks for the Rebate Distribution component have been identified.

4.0 Medicaid Part D Reporting

Proper administration of the Medicaid Part D program will require reporting of benefit and program information at the State and Federal levels. Specific reports have not been defined at this time, however it is expected that a majority of the reporting will be done using information from MMIS.

Reporting from applicable systems used to administer the Medicaid Part D program will primarily be used to facilitate the following measures:

1. Quantify the number of individuals in the Medicaid Part D waiver
2. Compare and contrast the number of Medicaid Part D waiver participants with Medicaid recipients
3. Assess insurance coverage levels in the State by coverage sources (Medicaid, CHIP, Employer sponsored insurance, COBRA, etc...)
4. Compare and contrast the Medicaid Part D waiver populations, Medicaid recipients and the Montana population as a whole using demographic indicators (age, sex, income, race-ethnicity, etc)
5. Identify the amount of drug rebates to uninsured individuals and individuals with TPL
6. Identify the amount of supplemental drug rebate to be used by DPHHS for administrative costs
7. Quantify the number and rate of Medicaid Part D waiver individuals covered by employer sponsored, private insurance plans, other group health plans including COBRA, etc.
8. Compare and contrast the Medicaid Part D waiver population, Medicaid recipients, and the Montana populate as a whole using demographic indicators, covered by employer sponsored insurance plans and private insurance plans.

9. For Medicaid Part D waiver participants, track changes in the uninsured rate and trends in sources of insurances.

The measures above will utilize data from the online applications, MMIS, PDCS, and DRAMS. Data gathered from these reports will be used in conjunction with other data sources in order to provide information for each measure.

Glossary

(MI) Montana Interactive – Montana Interactive LLC in Helena, MT is a private company categorized under Web Page Design Software or hardware engineering, Computer programmers, Management information systems MIS, System administrators, Information retrieval systems, Data services, Internet services, Software maintenance and support.

(CHIMES - Medicaid) Combined Health Information and Montana Eligibility System – is a modern Medicaid eligibility system that will replace the Medicaid component of The Economic Assistance Management System (TEAMS).

(PDCS) Prescription Drug Claim System – Is the Department's pharmacy claim processing system.

(POS) Point of Sale – A terminal where a pharmacy claims transaction takes place.

(DRAMS) Drug Rebate Analysis/Management System –The Department's drug rebate invoice processing system.

(MMIS) The Medicaid Management Information System –The Department's physical and mental health claims processing system.